MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00850

83 ★

CERTIFICATE OF DEATH

Reg. Diat. No. 2820

1. PLACE OF DEATH:

County St Marys

City or town Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:
Leonardtown Md

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Pathsent River Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Yarnell Bryant

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Nancy Bryant

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 25 - 1879

8. AGE: Years	Months	Days	If less than one day
67		20	..... hrs. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER 12. Name George A. Bryant

FATHER 13. Birthplace Washington D.C.

MOTHER 14. Maiden name Carolyn C. Bryant

MOTHER 15. Birthplace Baltimore Md

16. Informant John Y. Bryant

Address 317 Duke St Alexandria

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 1947 (month) (day) (year)

Cemetery or crematory St Paul M.E. Cemetary

Location Leonardtown Md

18. Funeral director W. C. Mattingley Sons

Address Leonardtown Md

19. 1/14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1947 at 2.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1942 to Jan. 13 1947

and that I last saw h.... alive on Jan 13 1947

Immediate cause of death Cerebral Hemorrhage — DURATION 2 days

Due to Hypertension

Due to Generalized Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm H Parran M.D.
M. D. or other

Address Lexington Park Md Date signed 1-13-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Evidence for the change of age is shown on G 108 1/10/47

00851

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 2860

1. PLACE OF DEATH:
County St. Mary's
City or town Rural River District
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County St. Mary's
City or town Rural River District
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Magdalene Brasfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widowed

6.(b) Name of husband or wife John William Brasfield
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 - 12 - 1875

8. AGE: Years	Months	Days	If less than one day
71	11	20	hrs. min.

9. Birthplace River Neck, St. Mary's Co. Md.
(Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business

FATHER 12. Name	Charles Edward Abell
FATHER 13. Birthplace	River Neck, Md.
MOTHER 14. Maiden name	Adelaide Christopher
MOTHER 15. Birthplace	River Neck, Md.

16. Informant John William Brasfield
Address Clements, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-4-47 (month) (day) (year)
Cemetery or crematory St. Andrews
Location Avenue, Md.
18. Funeral director W. C. Cheatham & Son
Address Leonardtown, Md.
19. 1-2-1947 (Date rec'd by registrar) Robert V. Palmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1-1947 at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27-1946 to 1-1-1947
and that I last saw h alive on 1-1-1947
Immediate cause of death Cerebral apoplexy (DURATION 3 D)
Due to
Due to
Other conditions Chronic Bronchitis
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer M. D. or other
Address Leonardtown, Md. Date signed 1-2-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

06852

CERTIFICATE OF DEATH

Reg. Diat. No. 282

1. PLACE OF DEATH:
County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Albert Talley

3.(b) Social Security Number:

4. Sex: male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of ~~husband~~ or wife: Mable L. Talley
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1877?
8. AGE: Years: 69? Months: Days: If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Charles Talley
13. Birthplace: Maryland
MOTHER 14. Maiden name: Nellie Swales
15. Birthplace: Maryland
16. Informant: Mable L. Talley
Address: Leonardtown
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/47 (month) (day) (year)
Cemetery or crematory: Old St. Andrews
Location: Leonardtown
18. Funeral director: P B Robinson
Address: Leonardtown Md.
19. 1/17 1947 Canalier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16, 1947, at 1:00 P. M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 7th 1947, to Jan 16 1947
and that I last saw h... alive on Jan 15 1947

	DURATION
Immediate cause of death: Bronchial Pneumonia	11 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Francis F Greenwell M. D. or other
Address: Leonardtown Md. Date signed: Jan 17 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

00853

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St Marys
City or town: Leonardtown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: St Marys Hospital Leonardtown Md
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: Bush Wood (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Ann Lacey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 8 - 1933

8. AGE: Years	Months	Days	If less than one day
13	5	19	..... hrs. ..... min.

9. Birthplace: Bush Wood St Marys Maryland (Town, county, and state)
10. Usual occupation: School
11. Industry or business

FATHER
12. Name: Dudley Lacey
13. Birthplace: Bush Wood, Md

MOTHER
14. Maiden name: Mary E. Knott
15. Birthplace: Bush Wood Md

16. Informant: Dudley Lacey
Address: Bush Wood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30 1947 (month) (day) (year)
Cemetery or crematory: Sacred Heart Cemetery
Location: Bush Wood Md
18. Funeral director: W. C. Mattingly Sons
Address: Leonardtown Md
19. 1/29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 - 1947 at 3:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21 1947 to January 28 1947 and that I last saw h.. alive on January 27 1947

Immediate cause of death	DURATION
Subacute Lymphocytic Leukemia	2-3 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert J. Fuchs M.D. (M. D. or other)
Address: Leonardtown, Md Date signed 1/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

CERTIFICATE OF DEATH

00854

Reg. Diat. No. 2820

1. PLACE OF DEATH:

County: St. Mary's

City or town: Rural, Clements

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: Clements, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Nellie Marshall

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): ? 1876

8. AGE: Years: 71? Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county and state)

10. Usual occupation: housekeeper

11. Industry or business

FATHER — 12. Name: ? Scott

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Louise Stewart

MOTHER — 15. Birthplace: Maryland

16. Informant: Wm. T. Marshall

Address: Clements, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/47 (month) (day) (year)

Cemetery or crematory: Newtown Neck

Location: Compton, Md.

18. Funeral director: H. B. Robinson

Address: Leonardtown, Md.

19. 1/8 (Date rec'd by registrar) 1947 Camalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1946, to Jan 7 1947

and that I last saw h— alive on Jan 7 1947

	DURATION
Immediate cause of death: Chronic Nephritis	
Due to: Senile Debility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank A. Camalier M. D. or other

Address: Leonardtown Md. Date signed 1/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00855

Reg. Dist. No. 2820

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County: St Marys

City or town: Leonardtown Park Beauson Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Leonardtown Park Beauson (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Warner White McKee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Henrietta Louise Oakes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 25 1862

8. AGE: Years	Months	Days	If less than one day
84	10	24	hrs. min.

9. Birthplace: Buffalo New York (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace

MOTHER — 14. Maiden name: Baker Allen

MOTHER — 15. Birthplace: Hamburg New York

16. Informant: Theodore S. B. McKee

Address: 43 Coral place Leonardtown Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22 1947 (month) (day) (year)

Cemetery or crematory: Pine Grove Cemetery

Location: Hope Valley Rhode Island

18. Funeral director: W C Smallwood Sons

Address: Leonardtown Md

19. 1/20 1947 Canales (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1947 at 1.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Deceased deceased on Jan 19th 1947

and that I last saw him alive on 19

Immediate cause of death	DURATION
Fibrillation of Heart Cause	5 minutes
Due to: Chronic Myocarditis	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Francis F Greenwell Coroner M. D. or other

Address: Leonardtown Md Date signed 1-20-47

1 - 35

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

00856

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:
County St. Marys
City or town Lexington Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
U.S.N.A.S. Dispensary, Patuxent River
How long in hospital or institution? 26 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Mass. County Suffolk
City or town East Boston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 40 Waldmar Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3. (a) FULL NAME John Joseph MOORE

3. (b) Social Security Number 265-18-5189

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Gladys MOORE
6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 26 February 1910

8. AGE: Years	Months	Days	If less than one day
36	10	25	4 hrs. 20 min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual occupation U.S. Marine Corps

11. Industry or business U.S. Marine Corps

FATHER
12. Name John J. Moore
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Doran
15. Birthplace Ireland

16. Informant Mrs. John J. MOORE
Address 40 Waldmar Ave., E.Boston, Mass

17. Transportation Date thereof 1-23-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Boston, Mass

18. Funeral director P. L. Robinson
Address Leonardtown, Md.

19. 1/20 47 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 January 1947 4:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 January 1947, to 19 January 1947
and that I last saw him alive on 19 January 1947

Immediate cause of death Injuries, Multiple, Extreme — DURATION 26 hrs.

Due to Multiple fractures of ribs on both sides with fracture of
Due to Stomach rupture of spleen and lacerations of both lungs

Other conditions Automobile accident
Int. hemorrhage Peritonitis
(~~Include pregnancy within 3 months of death~~)

Major findings of operations
Date of op.

Autopsy res Injuries, Multiple, Extreme

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 18 Jan. 47
Where did injury occur Lexington Park, St.Marys, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury struck by auto Injured at work? No

Francis F. Greenwell M.D. Coroner
Leonardtown Md
1-20-47

23. SIGNATURE J. O. Coudon, CDR. MC. USN M. D. or other

Address NAS, Patuxent River, Md. Date signed 1-19-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00857

CERTIFICATE OF DEATH

Reg. Dist. No. 7-8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Then correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: St. Marys
City or town: Great Mills, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, institution, or street address where death occurred: Dispensary, NAS, Patuxent River, Md.
How long in hospital or institution? 50 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Lackawanna
City or town: Scranton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 219 Pittston Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: NEUREUTER, Joseph Valentine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-14-20

8. AGE: Years	Months	Days	If less than one day
26	11	10	hrs. min.

9. Birthplace: Scranton, Pennsylvania (Town, county, and state)
10. Usual occupation: BKRl
11. Industry or business: U.S. Navy

FATHER
12. Name: Nicholas Neureuter
13. Birthplace: Scranton, Pa.

MOTHER
14. Maiden name: Ann Hannigan
15. Birthplace: Dunmore, Pa.

16. Informant: Nicholas Neureuter
Address: 219 Pittston Ave., Scranton, Pa.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof 1/26/47 (month) (day) (year)
Cemetery or crematory: Scranton, Pa.
Location:
18. Funeral director: JB Robinson
Address: Leonardtown, Md.
19. 1/25 1947 Camalier (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-24-47 19 47, at 6:21 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-22-47 19 47, to 24 January 19 47 and that I last saw him alive on 24 January 19 47

Immediate cause of death	DURATION
Toxemia	
Biliary Extravasation	
Due to: Rupture of liver	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Rupture of liver. Intra-abdominal hemorrhage 1-23-47
Rupture of liver Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 1-22-47
Accident, suicide, or homicide: Accident Date of injury
Where did injury occur? Highway 235 St. Marys Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public place
Means of injury: Auto accident Injured at work? No.

23. SIGNATURE: Francis F. Greenwell Coroner M. D. or other
Address: Leonardtown, Md. Date signed 1-24-47

1-35

(over) write signature

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

00858

CERTIFICATE OF DEATH

Reg. Dist. No. 98 1

1. PLACE OF DEATH:

County St Marys

City or town Rural Valley Lee

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Rural Valley Lee

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Infant Shelton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of huaband or wife

6.(c) If alive, give age ..... yeara

7. Birth date of deceaaed (mo., day, yr.) Jan 30/47

8. AGE: Yeara | Months | Days | If less than one day: 2 hrs. ..... min.

9. Birthplace Valley Lee Md (Town, county, ond state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Francis Shelton

13. Birthplace Leonardtown Md

MOTHER 14. Maiden name Maggie Lawrence

15. Birthplace Valley Lee Md

16. Informant Francis Shelton

Address Valley Lee, Md

17. Burial (Burial, cremation, or removol. Which?) Date thereof Jan 30/47 (month) (day) (year)

Cemetery or crematory St Marks Cemetery

Location Valley Lee, Md

18. Funeral director Francis Shelton

Address Valley Lee, Md

19. Jan 30 1947 (Date rec'd by registrar) A P Benn MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1947, at 4.30 A M

21. I CERTIFY that death occurred on the date above atated; that I attended deceaaed from Jan 30 1947, to Jan 30 1947

and that I last saw h.. alive on Jan 30 1947

Immediate cause of death	DURATION
Premature birth (4 months)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please uoderline the caose to which death should be charged statistically.

22. VIOLENCE: If death was due to external cauaes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, indusiry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sophia X Clayton (Mid wife) (M. D. or other)

mark

Address Hermanville Md Date signed Jan 30/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

Letter sent To Co. Health Officer by Dr Hedrich.
(DR. M.A HARRIS)

Pull out 1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 a

00859

CERTIFICATE OF DEATH

Reg. Dist. No. 2820

1. PLACE OF DEATH:

County St. Mary's

City or town Charlotte Hall Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Charlotte Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Alice Woodland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 29, 1890

8. AGE: Years 57 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Benjamin Key

13. Birthplace Maryland.

MOTHER 14. Maiden name Elizabeth Washington

15. Birthplace Maryland.

16. Informant Mary Anglin

Address 2222 W. Fontain Phil. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)

Cemetery or crematory St. Joseph

Location Mosherville, Md.

18. Funeral director A. B. Robinson

Address Leonardtown, Md.

19. 1/20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24, 1946 19.. to Jan. 18 1947

and that I last saw h.. alive on Jan. 18 1947

	DURATION
Immediate cause of death Uremia	
Due to Congestive Failure	6 mos
Due to Hypertension cardiovascular-renal disease	yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Farren Jarboe M.D.

M. D. or other

Address La Plata Md. Date signed Jan 20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00860

Reg. Diat. No. 28-0

1. PLACE OF DEATH:
County St. Mary's
City or town Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
St Mary's Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Lovenille Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Helen Gimmesman 565

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) February 26, 1946

8. AGE: Years	Months	Days	If less than one day
0	11		hrs. min.

9. Birthplace Leonardtown Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name John Gimmesman
13. Birthplace Lancaster Pa.

MOTHER
14. Maiden name Mary Bigler
15. Birthplace Lancaster Pa.

16. Informant John Gimmesman
Address Loydsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-28-47 (month) (day) (year)
Cemetery or crematory Staughton, Cem.
Location Lovenille, Md.

18. Funeral director Elmer M. Veale
Address Hughesville Md.

19. 1-28-47 1947 Caveney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1947, to Jan 24 1947
and that I last saw h alive on Jan 24 1947

Immediate cause of death	DURATION
Tuberculosis (Lungs)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James A. Caveney M. D. or other
Address Leonardtown Date signed 1-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35